CHILD CARE STAFF HEALTH ASSESSMENT

Employer should complete this section.

Name of person to be examined: _____

Employer for whom examination is being done: _____

Employer's Location: _____Phone Number: _____

Purpose of examination:

❑ pre-employment (with conditional offer of employment) ❑ annual re-examination

Type of activity on the job:

❑ lifting, carrying children ❑ close contact with children ❑ food preparation
❑ driver of vehicle ❑ desk work ❑ facility maintenance

Part I and II below must be completed and signed by a licensed physician or CRNP.
Based on a review of the medical record, health history, and examination, does this person have any of the following conditions or problems that might affect job performance or require accommodation?

Date of Exam: _____

Part I: Health Problems:	(circle)	
Visual acuity less than 20/40 (combined, obtained with lenses if needed)?	Yes	No
Decreased hearing (less than 20db at 500, 1000, 2000, 4000 Hz)?	Yes	No
Respiratory problems (asthma, emphysema, airway allergies, current smoker, other)?	Yes	No
Heart, blood pressure, or other cardiovascular problems?	Yes	No
Gastrointestinal problems (ulcer, colitis, special dietary requirements, obesity, other)?	Yes	No
Endocrine problems (diabetes, thyroid, other)?	Yes	No
Emotional disorders or addiction (depression, drug or alcohol dependency, other)?	Yes	No
Neurologic problems (epilepsy, Parkinsonism, other)?	Yes	No
Musculoskeletal problems (low back pain, neck problems, arthritis, limitations on activity)?	Yes	No
Skin problems (eczema, rashes, conditions incompatible with frequent hand washing, other)?	Yes	No
Immune system problems (from medication, illness, allergies and sensitivities to materials)?	Yes	No
Need for more frequent health visits or sick days than the average person?	Yes	No
Other special medical problem or chronic disease that requires work restrictions/accommodation?	Yes	No

Part II: Infectious Disease Status (Complete Immunization Record on Back)

Immunization now due/overdue for:
Tdap (every 10 years)
MMR (2 doses for persons born after 1989: 1 dose for those born in or after 1957)
Polio (OPV or IPV in childhood)
Hepatitis B (3 dose series)
Hepatitis A
Varicella (2 doses or had the disease)
Influenza
Pneumococcal vaccine

Female of childbearing age susceptible to CMV or parvovirus?	Yes	No
Evaluation of tuberculosis status shows a risk for communicable TB?	Yes	No

Mantoux test date _____ Result _____

(Tuberculosis status must be determined by performing the Mantoux test (Intradermal, intermediate strength PPD injection with needle and syringe) for persons not previously tested positive for tuberculosis infection. For individuals over 55 years of age, and anyone with pulmonary symptoms, the Mantoux test should be performed twice if the first test is negative. The second test should be performed 1-3 weeks after the first test. Anyone with a previously positive Mantoux test who has symptoms suggestive of active TB should have a chest x-ray. All newly positive Mantoux tests should be followed by x-ray evaluation.)

Please explain all "yes" answers above on the back of this form. Attach additional sheets if necessary.

_____ _____ _____ MD DO CRNP
(Date) (Signature) (Printed last name) (Title)

Phone number of physician or CRNP: _____
I have read and understand the above information.

_____ _____
(Date) (Patient's Signature)

Check with your Health Department for changes annually.

CHILD CARE STAFF HEALTH ASSESSMENT

CHILD CARE STAFF HEALTH ASSESSMENT RECORDS

Child care providers must show documentation of immunity by immunization records or blood tests showing immunity.

VACCINE TYPE	VACCINE	DOSE	DATE GIVEN	DOCTOR
Varicella	Chicken Pox	2 doses		
IPV	Polio	4 doses in childhood		
Type A or Type B	Influenza	(Every Year)		
MMR	Measles Mumps Rubella	2 doses for persons born in or after 1957		
Tdap	Tetanus Diptheria	1 dose every ten years		
Hep B	Hepatitis B	3 doses		
Hep A	Hepatitis A	1 dose		

Additional comments _____

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